WC-365.1 (3-97)

State of New Jersey
Department of Labor
DIVISION OF WORKERS' COMPENSATION
CN 381
Trenton, New Jersey 08625-0381

EMPLOYEE'S CLAIM PETITION SUPPLEMENTAL PAGE

(DO NOT FILL IN)

CASE NO. ____________________

D.O. ____________________

Date of Accident or Dates of Occupational Exposure:

If Respondent Known By Different Name, Please Indicate Below:

INSURANCE CARRIER

NAME (Indicate if Not Covered or self-insured)
NJ REG. OR FEIN

ADDRESS

CARRIER'S CLAIM FILE NUMBER

PERIOD OF COVERAGE
FROM TO

INSURANCE CARRIER

NAME (Indicate if Not Covered or self-insured)
NJ REG. OR FEIN

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